U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

Clinical Baseline Assessment Instrument Set

1983

Office of the Assistant Secretary for Planning and Evaluation

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CLINICAL BASELINE ASSESSMENT INSTRUMENT SET

Temple University
Institute on Aging

1983

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Clinical Baseline Assessment Instrument: Community Version
Clinical Baseline Assessment Instrument: Institutional Version

ABSTRACT

DOCUMENT TITLE: National Long Term Care Demonstration Clinical Baseline Assessment Instrument Set 1983, 144 pp.

AUTHORS: Mathematica Policy Research, later modified by a group of Channeling Demonstration practitioners and staff at Temple University Institute on Aging

ABSTRACT: The National Long Term Care Demonstration Clinical Baseline Assessment Instrument (C-BAI) is a modification of the original clinical and research baseline assessment instrument (BAI) used in the Channeling Demonstration. Once the research data collection phase for clients ended in June 1984, the original instrument was reviewed by a committee of demonstration participants and subsequently revised. While there were some restrictions on the revisions which could be made, the resulting C-BAI was shorter. Questions no longer needed for research were removed. Many of the original structured questions became unstructured optional follow-up probes.

The demonstration sites provided case management and community-based long term care services to very impaired elderly clients who wanted to remain in their own homes. This instrument was used to conduct face-to-face interviews of elderly clients who were being admitted to the program. If clients were unable to be interviewed, assessment information was obtained from proxies. Assessment interviews generally took 1-1½ hours to complete. Two versions of the form were used, one for clients being interviewed in their community residence and one for those currently in an institution, either hospital or nursing home.

Interviews were conducted by nurses or social workers with bachelor's or master's degrees. All workers received a standard training in the use of this instrument.

This set includes both institutional and community versions of the instrument. It also includes The Clinical Baseline Assessment Instrument Training Manual, designed to introduce workers to the instrument.

RELATED MATERIALS: Assessment Training for Case Managers: A Trainer's Guide. This trainer's manual provides extensive information on methods and procedures in the assessment process which was developed in Channeling. It contains an outline, course content, and all necessary materials for a 3-day training on the C-BAI. [http://aspe.hhs.gov/daltcp/reports/asmttran.htm]

SUMMARY DESCRIPTION OF PROGRAM CONTEXT

by Nancy Wilson and Linda Sterthous

History and Background

The problems and limitations of the current long-term care system have been described many times during the past decade. Policy-makers at all levels of government have stressed the need to resolve critical problems such as increasing public costs, excessive reliance on medical and institutional care, inadequate community resources, fragmentation, and service inaccessibility.

Since these problems affect a growing population of impaired elders, public officials and legislators have initiated a variety of long-term care demonstration projects to evaluate new approaches to services, increase understanding of the needs of impaired clients, and gather information about the costs of caring for them in the community.

To answer important remaining policy questions, Congress authorized funds for the National Long-Term Care Channeling Demonstration (known also as "Channeling"). From 1980 to 1985, three agencies within the Department of Health and Human Services jointly administered this demonstration project in ten states. The office of the Assistant Secretary for Planning and Evaluation coordinated and implemented the program, cooperating with staff from the Administration on Aging and the Health Care Financing Administration, the two principal funding sources.

The Channeling program has tested two organizational models of community-based long-term care for the functionally impaired elderly. Both models were tested as alternatives to institutional care and included these common features: a central point of intake, a standardized assessment process, and ongoing case management to arrange and monitor the provision of community-based services.

In the basic Channeling model, case managers coordinated existing community resources to meet individual needs. The complex (or financial control) model had additional authority and funding to purchase services for clients. These case managers had access to pooled funds from Medicare, Medicaid, Title III and Title XX and could authorize the amount, duration and scope of services for all of their clients within established site limits on total care plan costs.

Channeling Participants

Through DHHS contracts with ten states, ten community agencies were selected to carry out the Channeling demonstration. The basic case management model was tested in five sites: Eight counties in Eastern Kentucky; Portland, Maine; Baltimore,

Maryland; New Brunswick, New Jersey; and Houston, Texas. The five complex model sites were operated in Miami, Florida; Greater Lynn, Massachusetts; Troy, New York; Cleveland, Ohio; and Philadelphia, Pennsylvania. All ten sites began operating in early 1982.

The official closing date of the Channeling Demonstration was March 31, 1985. Each of the ten sites has gone through a termination/transition process designed to safely discharge clients to existing agencies or to move program staff and clients to other sources of funding.

During the course of the demonstration, the ten channeling sites identified through outreach efforts over 9,000 very impaired older adults and served over 6,000 of these individuals as clients.

Design of Channeling Demonstration

Channeling was developed to achieve the following objectives:

- Improved targeting of service resources to those in greatest need.
- Improved matching of clients needs to formal and informal services.
- Improved client outcomes.
- Less costly, more efficient use of services.

Target Population for Channeling

The Channeling Demonstration placed major emphasis on developing eligibility criteria designed to identify elders who were imminently at risk of entering an Institution. Thus, the standard criteria for participation in the project included the presence of functional disabilities as well as unmet needs or fragile informal supports.

Utilizing these eligibility criteria for a defined target population, the Channeling sites recruited and screened applicants for services. The profile of Channeling clients selected using these criteria reveals a very impaired population. Most of the clients were unable to leave their homes without human assistance and many were bedbound. Most needed assistance with activities of daily living.

To achieve improved client and caregiver outcomes <u>and</u> reduced costs for more appropriate services, the designers of Channeling prescribed seven essential core functions that each site was to carry out:

A. <u>Outreach</u> to identify and attract appropriate clients. Channeling sites utilized a variety of outreach strategies including: written referral agreements with hospitals, home health providers and other agencies who referred clients, community education activities aimed at clients and families (such as letters to clergy and

group presentations); and public information such as media announcements and brochures. The major sources of referral were hospitals, home health agencies, and families.

B. Screening to determine whether an applicant was part of the target population. Designated staff typically conducted a telephone interview of 15-20 minutes with a client or referral source, using a standardized screening instrument. The instrument included questions designed to establish an individual's eligibility for the program based on the criteria previously discussed. Screeners decided when to rely upon a family member or other referral source instead of a client as a respondent to the screening questions.

C. Comprehensive needs assessment to determine individual problems, resources, and service needs. Using a standardized assessment tool, the channeling staff made an in-person visit to collect information about a client's current functioning and support system. Staff used one version of the tool for clients assessed in an institution (hospital or nursing home) and another version for community clients. Both Instruments explored aspects of the client's physical health, mental health, social functioning, activities of daily living, financial resources, living environment, current services and support and unmet needs. Additional information was collected as needed from other formal and informal providers involved with the client.

D. Care planning to specify the types and amounts of care to be provided to meet the Identified needs of individuals. At this stage, case managers translated identified needs and problems into a plan for services. Working with a standard care plan format, staff outlined problems, goals to be achieved, type of help to pursue in support of goal attainment, and sources and cost of services.

Case managers were trained to be cost-conscious in their selection of service packages. They were encouraged to consider the full spectrum of public and private services available to a client before choosing an appropriate package. This included maximizing informal care already in place or potentially available to the client, and seeking volunteer help.

An important aspect of the care planning process was establishing an agreement with the client and significant family members. In Channeling, a care plan agreement form was signed by clients signifying their knowledge and cooperation with the plan.

E. Service Arrangement to implement the care plan through both formal and informal providers. Case managers had to be knowledgable about service availability in their respective communities. This step sometimes required extensive communication with client, family and providers to assure that quality help would be provided and services were scheduled appropriately.

F. Monitoring to assure that services are provided as specified in the care plan. To monitor service provision and the circumstances of their frail clients, case managers maintained contact by telephone or in person with providers, clients, and family members. They encouraged informal and formal providers to call in the event of problems with services or changes in client status. Case managers relied on in-home providers to provide information about clients in crisis. Clients with no functioning informal care system often required more Intensive follow-up.

G. Reassessment to adjust care plans to changing needs. In Channeling, reassessment was conducted on a scheduled basis, three months after program entry and every five to six months thereafter. In addition, a client's status changed suddenly in some major way, an "event-based" reassessment was conducted to revise the care plan. The case manager conducted an in-person visit and, utilizing a structured form, re-examined the client's situation and functioning. The reassessment was the basis for continuing, revising or discontinuing services and for determining whether the client continued to need case management services.

CLINICAL BASELINE ASSESSMENT INSTRUMENT TRAINING MANUAL

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Mathematica Policy Research
May 1982

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September 1983

Annotated and Edited for Use in C-BAI Training

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CHANNELING C-BAI FACT SHEET

The National Long Term Care Demonstration Clinical Baseline Assessment Instrument (C-BAI) is a modification of the original clinical and research baseline assessment instrument (BAI) used in the Channeling Demonstration. Once the research data collection phase for clients had ended in dune 1984, the original instrument was reviewed by a committee of demonstration participants and subsequently revised. While there were some restrictions on the revisions which could be made, the resulting C-BAI was shorter. Questions no longer needed for research were removed. Many of the original structured questions became unstructured and optional follow-up probes.

The demonstration sites provided case management and community-based long term care services to very impaired elderly clients who wanted to remain in their own homes. This instrument was used to conduct face-to-face interviews of elderly clients who were being admitted to the program. If clients were unable to be interviewed, assessment information was obtained from proxies. Assessment interviews generally took 1-1½ hours to complete. Two versions of the form were used, one for clients being interviewed in their community residence and one for those currently in an institution, either hospital or nursing home.

Interviews were conducted by the case managers, or in two sites, assessors. These workers were generally nurses or social workers with bachelor's or master's degrees. All workers received a standard 4-day training in the use of this instrument.

Both an instruction manual and a trainer's guide for conducting a 3-day training are available for the cost of copying from Temple University - Institute on Aging, 083-52, 1601 North Broad Street, Philadelphia, PA. 19122. The trainer's guide has been revised so that it can be adapted to any program which might incorporate the C-BAI.

I. INTRODUCTION[1]

A. The Policy Problem

Public expenditures for long term care services, especially for nursing homes, have increased rapidly in recent years. In 1960, public expenditures for nursing home care totalled 500 million dollars. By 1978, Medicaid expenditures for nursing homes, which consititute the majority of public expenditures for that purpose, had risen to 7.6 billion dollars. Nursing home care now consumes nearly 41 cents of every Medicaid dollar spent in the United States.

For a variety of reasons--improved medical technology, increased financing for health care through Medicare and Medicaid, improvements in sanitation and public health, and demographic trends--the U.S. population is, on average, older. As a consequence, public and private expenditures on long term care services will continue to increase. Although only 2 percent of persons in their sixties live in nursing homes, that percentage increases steadily with age, reaching 14 percent for those over 85. One-fourth of the elderly are now over 80. This proportion is predicted to grow over the next 20 years to one-third. Thus, the potential pool of nursing home residents will grow even faster than the over-65 group In general. The national commitment to providIng for the nation's elderly is strong and can be expected to remain so. But the trends just mentioned, combined with concern about government budgets, will inevitably make it more difficult to choose between simply prolonging life and improving its quality.

Nor is the growing elderly population the only aspect of the long term care problem. It is also widely argued that, despite increasing expenditures, the long term care system is not adequately providing for the elderly. A number of studies have shown that many nursing home residents are unnecessarily placed in institutions. While estimates of improper nursing home placement vary considerably--anywhere from 10 to 40 percent--there is general agreement that the current system places-too much reliance on nursing home care. Inappropriate placement has not been limited to nursing homes. Recent studies have also found a backlog of chronically ill elderly patients in acute care hospital facilities, due primarily to a lack of Medicaid nursing home beds. These mismatches of services and needs are wasteful and adversely affect the psychological well-being and quality of life of those in need of care.

Critics of the current long term care system identify two major causes of the overreliance on institutional care: fragmentation of the existing service delivery system and financial incentives that favor medical over social services and institutional over noninstitutional care.

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[1] NOTE: If your program involves community based long term care for the elderly, this chapter is appropriate for your use.

Community-based, noninstitutional services currently offered are, critics argue, fragmented, poorly coordinated, and in some cases underdeveloped. The Select Committee on Aging identified over 130 programs in the current service system that provide some service to the elderly. Because these programs are administered by a diverse group of federal, state, and local agencies, there is considerable potential for clients to get lost in the system or to be unaware of the availability of services that could allow them to remain in the community. Critics charge that finding one's way through the maze of programs available can be so difficult that some in need of long term care enter nursing homes because it Is the simplest alternative, while others remain in the community but without adequate help.

In addition to the fragmentation of the existing delivery system, federal financing is strongly biased in favor of medical services in general and institutional care in particular. Home care advocates have argued that individuals are being forced into nursing homes because of inadequate government financing for in-home services. Funding for in-home services has actually been reduced in some states as Title XX funds, capped from 1974 to 1979 and only minimally increased since then, have lost ground to inflation. Faced with a choice of Medicaid-financed nursing home care versus life in the community requiring homemaker services which they must pay for from their own pockets, the impaired on limited incomes may feel compelled to choose Medicaid placement.

Over the past five years, some promising programs have emerged to address these perceived inadequacies. At the core of many of these programs has been a commitment, at the local level, to develop a capacity to organize and manage a range of in-home, community, and institutional services on behalf of individuals who need long-term care.

ADD HERE INFORMATION ABOUT YOUR PROGRAM, ITS LEGAL AUTHORITY, AN OVERVIEW OF THE INTERVENTION AND PROJECT ORGANIZATION. IF YOUR PROGRAM HAS A RESEARCH' COMPONENT, DESCRIBE THE RESEARCH DESIGN AND QUESTIONS TO BE ADDRESSED BY THE RESEARCH.

B. Use of This Manual

This manual is designed to provide each assessor with a detailed guide to his or her responsibilities and to the procedures necessary for fulfilling them. It covers topics ranging from general issues and procedures (for example, confidentiality of data and principles of interviewing) to specific information about the administration of the clinical baseline assessment instrument (C-BAI). This manual is designed to provide the assessor with a framework within which to operate. A certain amount of interviewer creativity, ingenuity, and flexibility is essential.

Before beginning to interview, the assessor must be thoroughly familiar with this manual. Detailed in-person training will be given, followed by as much review as is

necessary. This manual is a reference book and it should be used whenever needed. In addition, supervisors who have had special training will be able to offer help and guidance when necessary.

C. Training Interviewers

Extensive training on the instruments is necessary to familiarize interviewers with the content of the instruments and prepare them for the process of using the instrument in an Interview. Training is crucial because the questionnaires are complex and assessors must be familiar with proper interviewing techniques.

Training on the C-BAI will emphasize Interviewing techniques designed to obtain unbiased answers from clients or proxies, requirements of the program and special issues which arise In Interviewing the frail elderly.

II. INTERVIEWING

A. Interviewing To Avoid Bias

Interviewer bias is any influence that changes an answer from what it might have been without that influence. There are five common errors which interviewers make which can bias responses. It is important to be aware of these possible errors at all times, because it is very easy to relax your professional attitude and bias responses. Even among well-trained and experienced interviewers, interviewer bias is common. To avoid interviewer bias, follow these rules:

- DO NOT express your own opinions or attitudes to the respondent. This may cause the respondent to change his/her answers to make them fit your attitudes and opinions.

- DO NOT reword questions. Rewording questions lead to different answers.

- DO NOT suggest answers. Even if you think you know the answer the respondent is searching for, you may well be wrong and respondents are likely to agree with you rather than express their true opinion.

- DO NOT use leading probes. Probes which suggest an answer can result in biased responses. This issue is discussed in detail in the next section.

- DO NOT let your attitudes, laziness, or carelessness allow you to record the response inaccurately. Your attitudes may cause you to "hear" the answer incorrectly if it is not what you expected. Also, you may attempt to seek a "better" response when the response offered was actually the true feeling of the respondent. When this happens, the actual response is lost. If in doubt, repeat the answer for the respondent to be sure you heard it correctly. Other recording errors result from simple carelessness; pay close attention to the recording of answers.

Using Non-directive Probes

Respondents will not always answer the question in a way that will enable you to circle one of the answer categories in the questionnaire. When this occurs, you must prompt them for a more specific answer; this prompting is called probing. When you probe, you must not lead the respondent to provide a particular answer. A probe is leading if it suggests an answer in any way. Leading will bias responses. To avoid this type of interview bias you must use non-leading or non-directive probes. "You don't need any help, right?" is a leading probe, while "Do you need any help?" is a non-directive probe.

There are seven basic kinds of non-directive probes you will need to use while interviewing:

- pausing,
- rereading the question,
- asking for more information,
- stressing generality,
- stressing subjectivity,
- zeroing in,
- repeating the response.

Each of these is discussed below.

Merely pausing after the respondent's answer is often the best way to indicate that the answer was inadequate. The respondent will then usually think further and provide a better answer.

Reread the question if the answer indicates that the respondent did not fully understand it. Stress any key words you feel the respondent may not have understood.

If the respondent does not provide enough information to answer the question, use a probe to ask for more information. For example:

Assessor: "Are **you** on a special diet?"

Client: “Well, I'm not sure if it's a special diet or not."

Assessor: "Did anyone ever tell you to avoid certain foods?"

Client: "Oh, yes, my doctor told me not to eat salt, so I try not to."

Assessor: "Did someone usually lift you out of bed or a chair?"

Client: "My sister helps me when I don't feel well."

The respondent has indicated that under some conditions (when he/she does not feel well), the answer is "Yes" and at other times it is "No." The assessor must use a probe to help the respondent generalize (make an overall judgment) about what usually happens. In this case, asking about the usual situation is an effective probe.

Assessor: "When you get out of bed or a chair, does your sister usually help you?"

Client: "Oh no, only once in a while when I am weak."

The interviewer can then code "NO."

Many questions are intended to determine a respondent's opinion or feeling about something. If the respondent does not understand this, it may be necessary to probe to stress that a subjective opinion is the correct answer. For example:

Assessor: "How would **you** rate your overall health at the present time -- would you say excellent, good, fair, or poor?"

Client: "Oh I don't know, you'll have to ask my doctor about how healthy I am."

Assessor: "In **your** opinion would **you** say **your** health at the present time is excellent, good, fair, or poor?"

Client: "Oh, you want my opinion. Well, I guess my health is just fair."

The interviewer can then code "FAIR."

Many respondents will have a hard time remembering or calculating exact numbers, such as days spent in institutions and the number of visits made by family, friends or helpers. In these cases, the interviewer must help the respondent remember as much as possible by using probes to zero in on the best estimate. For example:

Assessor: "In the last year, how many times were **you** admitted to any kind of hospital?"

Client: "That's a hard question, I'm really not sure."

Assessor: "When was the last time you were in the hospital? Do you remember your date of admission"?

Client: "Yes, it was just before Christmas, December 22."

Assessor: "And how about the time before that?"

Client: "Before that, I was mostly at home. But there was one time in the summer when I was in the hospital."

Assessor: "Was there any other time in the last year when you were admitted to any kind of hospital?"

Client: "No."

Assessor: "So would you say that you were in the hospital on two different occasions during the past year? Is that correct?

Client: "Yes, I guess it hasn't been as many times as I first thought. Two times is right."

The interviewer can then code two admissions.

Sometimes the answer the respondent provides will not make sense to you. You should not look surprised or skeptical, simply repeat the response in the context of the question to give the respondent a chance to reconsider the answer. For example:

Interviewer: "How often did **your** son come to help you?"

Client: "A lot, about 20 times a week."

Interviewer: "Let's see, your son came to help you about twenty times a week. Is that correct?"

Client: "Oh, did I say that? I meant about twenty times a month, once every weekday."

If an answer appears inconsistent with an earlier response, you may also refer to the earlier response to help clear up the inconsistency. In doing so, phrase your remarks to Imply that you have misunderstood something or recorded something incorrectly. Avoid the implication that the respondent made an error. For example:

Assessor: "Now, please tell me the people who regularly (come to) help you as part of their paid or volunteer work. These could be people who come from an agency or organization or (people you or your family hired/people on the staff here).

Client: "No one, there's no one like that."

Assessor: "I see. I*think I've got something wrong. Back here I wrote down that a nurse from the Visiting Nurse's Association comes once a week to change your bandages."

Client: "No, she used to come. She doesn't come any more. Now my daughter changes the bandages."

The interviewer should go back and correct the error in the earlier question. If you cannot clear up an apparent inconsistency by non-directive probing, make a note in the margin to indicate that you tried to do so and record the respondent's answers as given. Don't badger the respondent.

B. Scheduling Information from the Screen

Information from the screening instrument will be given you by your supervisor when assignments are made. The following information about the client may be useful to you:

- Name
- Permanent street address
- Permanent telephone number
- Subsample status
- Birthdate
- Medicare number or Social Security or Railroad Retirement number (in that order)
- Issues related to communication and administration
- Need for someone else to be present to assist with informed consent or the interview
- Directions to client's dwelling, if necessary.

C. Obtaining Informed Consent

YOUR SPECIFIC PROGRAM GUIDELINES FOR OBTAINING INFORMED CONSENT SHOULD BE WRITTEN HERE.

- What is your program's policy about obtaining informed consent?

- What are your procedures for indicating that a client is informed about the program, understands how the information he or she provides will be used, and agrees to participate?

- Will you use release of information forms, signed by the client to obtain information from other agencies and providers?

This should all be handled with a client and/or family before the baseline assessment interview begins. You may want to read the form aloud while the client follows along.

If the client has a legal guardian, you will have to obtain informed consent from the legal guardian before interviewing the client. A conservatorship is a "junior" form of legal guardianship and is treated the same way in obtaining informed consent.

You may learn that there is a legal guardian or conservator when scheduling the interview. Respondents are often confused about whether legal guardianship and conservatorship exists; if either is reported to you, probe by asking, "Does NAME OF LEGAL GUARDIAN, CONSERVATOR, PAYEE sign all documents for you?" If the

respondent says yes, that legal guardian signs all documents, then you must get the legal guardian's signature on the consent form. If the respondent gave permission for someone else to sign documents (for example, a power of attorney) but can still sign for him/herself, then the respondent does not have a legal guardian or conservator.

If a client has no legal guardian or conservator, is able to understand the informed consent, but is physically unable to sign the form, a witness must sign indicating that the client agreed to participate. If possible, have the client make his/her mark. Please write an explanation on the form, of why the client cannot sign. If the client has no legal guardian or conservator, but is unable to understand the informed consent, you may get a significant other to sign the consent form. The significant other should be someone with substantial involvement in the client's care, preferably a family member.

All information on the consent forms, including the signatures, must be in black Ink so that they can be copied clearly.

Remember to fill in the names of agencies or organizations from which services are received. Review these with the client when you finish the interview. If respondents do not know the names of the provider agencies, ask them to sign the consent form leaving provider names blank, so that you do not have to come back just to get their signature. Recontact the client who signed the consent form, by telephone, to 'review the list after you have identified any missing agency names.

D. Proxy Respondents

Rules for Going to Proxy Respondents

There are two situations in which you will need to contact a proxy respondent:

a. When your supervisor indicates, based on the screening information, that the client is not capable of being interviewed at all. Note, however, that if the client is capable of understanding, you must get his/her informed consent (assuming there is no legal guardian).

   Follow program specific procedures here.

b. When you must break off an interview because the client becomes very confused, disoriented, anxious or exhausted. (This may occur at any time during the Interview.)

If referred to a proxy to answer a particular question, the interviewer will write a marginal note explaining that a proxy should be contacted for information on that subject.

If the client refuses to answer questions in a series (or refuses to allow a proxy to be contacted), the interviewer will note that in that margin and circle "-1" for the questions refused. If the client refuses to give information, a proxy should not be contacted. It is not appropriate to ask proxies for information clients were unwilling to give about themselves.

When a question is answered by a proxy, put a "P" in the margin to indicate that. If a whole interview or a whole section is done with a proxy, mark the form prominently; then a "P" beside each question isn't needed.

The appropriate choice for a proxy respondent depends upon the client's situation. Take the following as proxies in the order listed:

a. someone assisting with the completion of the interview

b. someone else present in the dwelling at the time of the Interview

c. a relative or friend or formal caregiver who lives in the same household as the client

d. a relative, friend, or formal caregiver who does not live in the same household.

In each case the proxy respondent must be familiar with the client and his or her situation. If it is not obvious that someone assisting in the interview or present in the household is familiar with the client and his or her situation, ask the client whether the potential proxy respondent is "a good person to answer questions about you and your situation." The proxy should be someone who lives in the same general geographic area (not, for example, a child residing several hundred miles away).

When you have identified a proxy respondent, check to see whether you already know that person's address and telephone number.

If, in your judgement, substantive portions of the information the client gave you are unreliable, you may repeat these portions with the proxy respondent.

Contact with a proxy may be by telephone, unless you are doing the whole interview with a proxy.

E. Editing Work

Editing Checks

During your edit, check the following points:

Neatness and Legibility. All answers must be recorded so that they can be read easily. Circles should be clear; open-ended responses should be written clearly. Any marginal notes should be detailed and complete.

Right-justifying Numbers. All numerical answers must be right-justified, with leading zeros as appropriate. When editing, be sure you have all the boxes filled in.

Asking All Required Questions. Every question that should be asked (to comply with skip directions), must have an answer recorded for it. If you find that a question was missed, recontact the respondent for the missing information as soon as possible. You may get the information over the telephone.

Inconsistencies. The interview makes sense only when viewed in its entirety. The questionnaire was designed to follow a logical pattern, with each question and series of questions being interrelated. Interviewer training will point out which questions are so related. In editing the questionnaire, check to see whether the information is consistent. However, respondents are sometimes inconsistent. If, in editing, you find an inconsistency that you did not recognize and attempt to deal with in the interview, consider whether it is important enough to recontact the respondent.

III. FORMAT CONVENTIONS

This chapter explains the format conventions used in the C-BAI.

A. Capital and Lower Case Letters

Sentences, phrases, and alternative answer categories written in lower case letters are read aloud to the respondent. For example, in the following question the interviewer would read the answer categories aloud (except for "NOT ANSWERED"):

How would **you** rate **your** overall health at the present time--would **you** say

excellent,. 01
good,. 02
fair, ... 03
or poor?. 04
NOT ANSWERED . . -1

Sentences, phrases, or alternative responses written in all capital letters are <u>not</u> read to the respondent. In the following example, the Interviewer does not read the answer categories aloud:

What kind of transportation **do you** usually use?

PROBE: What about going to the doctor?

BUS/SUBWAY. 01
CAR/VAN/TAXI 02
AMBULANCE ONLY 03
DOES NOT TRAVEL AT ALL 04
NOT ANSWERED . . . . . -1

Interviewer instructions (which are not read to the respondent) are always written in all capital letters. These will be discussed further.

B. Underlining

Underlining is used for two purposes: to indicate that certain words should be stressed or emphasized and to indicate that the interviewer must substitute an appropriate word or phrase.

1. <u>For Stress or Emphasis</u>

Underlined words or phrases <u>in lower case</u> letters should be stressed when reading the question; that is, they should be pronounced more slowly, clearly, and emphatically than the rest of the question. Words indicated for stress are controlling

words in a sentence which must be understood by the respondent before a satisfactory answer can be given. Consider the following example:

Are **you** <u>able</u> to take care of money for day-to-day purchases by **yourself**?

YES 01
NO 02
NOT ANSWERED . . . -1

In this example, emphasizing able makes clear to the respondents that we want to know what they are able to do, not what they actually do. If this word was not stressed, it Is possible the respondent could misunderstand the question and provide an incorrect answer without the interviewer knowing that the question was misunderstood.

2. <u>Substitution</u>

Underlining associated with a word or phrase in all capital letters requires the interviewer to substitute a specific name or date for the underlined, capitalized word or phrase.

<u>Name substitution</u>. Name-substitution may be specific to the particular interview or may apply to all interviews administered at a particular site. The word <u>NAME</u> used alone indicates that the interviewer is to substitute a name or relationship specific to that respondent. Consider, for example, the question appearing in the instrument as,

"When is <u>NAME</u> generally at home to help **you** if **you need** it?"

Here <u>NAME</u> refers to the person mentioned in an earlier response as a helper of the client. If the helper had been identified as John, the interviewer would ask,

"When is John generally at home to help **you** if **you need** it?"

If the respondent had identified his wife as a helper, the interviewer would ask,

"When is **your** wife generally at home to help **you** if **you need** it?"

If the substitution applies to all interviews at your program, that is indicated in the underlined, capitalized phrase. In the following example, you would substitute a name specific to your program:

Do you have help with transportation from an agency or organization, like <u>LOCAL NAME</u>?

YES 01
NO 02
NOT ANSWERED . . . -1

C. Alternative Wording

Some questions must be read differently in different situations. These are indicated in three ways:

- parentheses
- boldface type
- interviewer instructions.

1. Parentheses

Questions with parentheses require the interviewer to decide which wording is appropriate, based on the situation." In some situations the interviewer must decide whether to include or omit a parenthetical phrase. In other situations the interviewer must choose between somewhat different words or phrases separated by a slash.

This example illustrates inclusion or omission of a parenthetical phrase.

> "(With **your** glasses or lenses) can you see well enough to read the labels on **your** medicine bottles or see the numbers on a telephone?"

The phrase, "With your glasses or lenses" is put in parentheses to alert the interviewer that it is not to be read to every respondent. You would read “With your glasses or lenses” only if the respondent reported the use of glasses or lenses several questions earlier.

The next example is an especially complicated one on the use of alternative phrases.

> "When **you leave** the (hospital/nursing home), do **you** feel that **you** will need (help/more help) with getting out of bed or a chair (than **you** will have at home)?"

In this case you would have to choose between reading "hospital" or "nursing home" in the first parentheses, depending on the type of institution the client was in at the time of the interview. Then, you would have to choose between "help" and "more help," depending on whether the client had reported (three questions earlier) receiving any help getting out of bed or a chair. Finally, you would read "than you will have at home" if you have read "more help."

2. For Proxy Respondents

The wording in the instruments is designed for clients to answer as self-respondents. When a client is unable to complete the interview and a proxy respondent is used to collect data about the client, you must change the wording of most questions, using the client's name or relationship to the proxy (or an appropriate pronoun) rather

than the word "you." The gender of verbs must sometimes be changed in a corresponding way. The words that must be changed for proxy respondents are indicated in boldface type. Consider this example:

> "Considering how **you have** been feeling the past week, could **you** do heavy work around the house, such as cleaning floors, by **yourself**."

When you ask the question of a proxy respondent not related to the client, you would use the client's name.

> "Considering how she has been feeling the past week, could Mrs. Smith do heavy work around the house, such as cleaning floors, by herself?"

(Note that the verb changes from "have" to "has.") For a proxy respondent related to the client you might use the relationship. For example:

> "Considering how she has been feeling the past week, could your mother do heavy work around the-house such as cleaning floors, by herself?"

D. Negative Numbers for Missing Values

Negative numbers are used for missing values so that the same missing codes can be used for every question. Any positive number used consistently would overlap with the answer categories of some questions.

You will notice that most questions have an answer category of "NOT ANSWERED," with a code of "-1" for missing values. Circle this code if you ask the question and the respondent does not know the answer or refuses to answer the question. If a respondent says, "I do not want to answer that question," you should explain the purpose of the question. If the respondent still refuses, reply "Okay, you don't have to answer any question you don't want to answer," and code "-1." If a respondent does not know the answer or cannot decide, pause to give them time to think about it. If they continue to insist they do not know, code "-1." Note, however, that some questions in the institutional version have a separate code (not a missing value) for cases in which the respondent is uncertain. In these questions, respondents are asked what their situation will be when they leave the institution. It is quite likely that they will be uncertain about this and a separate response category has been provided.

The other negative value code in the questionnaire is "-4." This is used to indicate that the question is not applicable in situations in which the skip pattern does not direct you to skip that question. For example, the code "-4" appears in the first column of each of the support system grids and is to be circled if there is no caregiver of that particular type. It indicates that the grid is not applicable for that client.

E. Interviewer Instrucitons

Interviewer instructions are not read to the respondent, but are either questions to collect information that interviewers can code by themselves or are instructions to interviewers to guide them in proper administration of the questionnaire. Interviewer instructions are in all capital letters to indicate they are not to be read to the respondent.

An example of a question to collect information that can be answered by an interviewer without asking the respondent is,

> "CAN THE RESPONDENT HEAR WELL ENOUGH TO UNDERSTAND NORMAL CONVERSATION (WITH A HEARING AID IF USUALLY WORN)?"

This question is designed to collect Information that the interviewer can provide. (In this case the interviewer would have to ask this question of a proxy respondent if the interviewer had no contact with the client.)

Statements to guide interviewers tell you what to do or how to deal with a particular question. Some interviewer instructions are enclosed in single solid-line boxes. For example,

DO NOT ASK OF A PROXY RESPONDENT

instructs you to ask the questions which follow of clients only.

Code Without Asking[2]

There is no need to ask or repeat the question if the assessor already knows the answer. For example, if the assessor knows why a client cannot perform an IADL, that can be coded or written on the line provided without asking the client.

F. Skip Instructions

Not every question is asked of all respondents. Skip instructions indicate questions which the interviewer should skip because they are not relevant to a particular respondent. Most skip instructions are located after the answer codes; the question number to be asked next is given in parentheses. For example,

[2] **Note**: Assessors can code any given question without asking it if the respondent has given them the information directly during the course of the assessment. Do not code without asking if the information came from the screener or referral sources.

"During the past week, did someone usually help you eat
or stay in the room in case you needed help eating?

YES, USUALLY HELPED 01
NO, NOT USUALLY HELPED. 02 (C3)
IV, TUBES 03 (C4)
NOT ANSWERED . . . . . -1 (C3)

If the respondent replied "Yes," you would proceed to the next question because there is no skip instruction after "01." If the respondent indicated eating without help, you would go to question C3 next, as the skip instruction after "02" indicates. If the respondent indicated being fed with an IV (intravenously) or through tubes, you would ask question C4 next, as the skip instruction after "03" indicates. Finally, if the question was not answered, you would skip to C3 after circling "-1." Some skip instructions are in boxes. For example,

IF THE CLIENT HAS BEEN UNABLE TO GET OUT' OF BED FOR MORE THAN ONE MONTH, OR WHEN LIFTED OUT STILL CANNOT AMBULATE, SKIP TO B16.

G. Grids

Grids are used when the same set of questions is to be asked repeatedly for different referents. The only grids in these questionnaires concern various types of support systems. The same set of questions is asked for up to three people who help the client in each of three support systems - household, informal and formal. The questions for each helper are listed down the left side of the grid with the answer categories listed in the columns under the name of each helper. For the formal support system grid after listing the helpers across the top, ask questions E15 to E19 for each and record the answers in the columns.

H. Brackets [ ]

Suggestions for relevant clinical probes are noted in brackets after each question. These are not required probes and the assessor will decide as the interview proceeds whether each one is relevant to the client being interviewed.

I. Stars * - Skip for Bedbound Clients

Questions with stars include all unmet need questions and questions about activities which can be performed by bedbound clients, e.g., telephoning. Clients who have been confined to bed for more than one month, or clients who can be assisted out of bed but cannot ambulate and are confined to a chair, are asked only the starred questions in this section. This approach is also used on the social support grids for clients who have been institutionalized for a prolonged period.

IV. SOME RULES FOR ADMINISTERING THE C-BAI

Clinical Questions

In general, the assessor is free to handle the interview in a manner she/he sees fit, within the parameters of good interviewing techniques. Latitude is offered the assessor in obtaining clinical information. These questions can be incorporated into the body of the interview at any time.

Order of Questions

The assessor will not be required to ask questions strictly in the order in which they appear within the assessment. The assessor has the freedom to complete sections in a way which is logical to the clinical assessment process and will need to develop a system for making sure that the total instrument is completed. In doing so, take care that you do follow the skip patterns within sections.

Subjective Questions

The assessor has some flexibility when asking the subjective questions H5, H6 & H7. The response categories (very satisfied, fairly satisfied, not very satisfied) are listed; however, the assessor has an option to omit them when asking the questions. Whether or not the assessor uses the response categories when asking the question, if the client's response does not easily fit into one of these categories, the assessor may write the client's own words on the lines provided and not press the client to choose one of the categories offered.

Wording of Questions

Assessors will be able to help clarify questions in their own words, as necessary, to help a client understand the meaning of what is being asked. However, questions should be asked as written on the form first, and assessors the form so that they may be used as should clarify with caution. Remember to avoid leading the client while clarifying.

Optional Questions

There are two questions in the C-BAI which can be designated as optional within your program. They are:

1) the SPMSQ, F5, and

2) H8 - The Physical Environment Checklist.

A decision will be made at your program as to how assessors will handle these questions. There is no special notation on the C-BAI about these optional questions.

Introductory & Transition Phrases

These phrases are included in needed. However, they are not required and assessors may reword them or eliminate them if they wish. It is likely that clinical probing will create transitions.

V. RECORDING ANSWERS

A. Black Pens

All answers must be recorded with BLACK ink. This is very important because the pages might be photocopied and blue ink does not photocopy clearly. [When you are interviewing, always carry 3 black pens to be sure you have at least one that is writing well.]

B. Right Justification and Leading Zeros

In all cases where a number is to be entered in boxes, enter only one digit per box. You must always "right justify" and use leading zeros for an answer entered in boxes; that is, if the number has fewer digits than the number•of boxes provided for it, write the number in the boxes to the right and fill in all blank boxes to the left with zeros. For example, if the respondent reported being admitted to the hospital twice during the past year, you would record,

ADMISSIONS. . . . |__|__|

If you recorded

ADMISSIONS. . . . |__|__|

the response could be interpreted as 20 times. When editing your work, pay close attention to the way numbers are recorded in boxes. Make sure all are right-justified with leading zeros.

C. Specifying

Some questions include the answer category (SPECIFY) followed by a line. If the respondent's answer does not fit one of the precoded categories, you should circle the code for "OTHER" and write the respondent's answer on the line provided. When you edit your work, check to see that you have circled the code as well as written in the answer.

D. Estimates

If, after you have probed, a respondent is unable or unwilling to give the exact figure asked for in a question, an estimate is acceptable. In this case, write "est." in the margin next to the question to indicate that the answer is an estimate. For example,

Assessor: Before taxes and deductions, how much is your (and your husband's/wife's) <u>total monthly</u> income?

ESTIMATE OK $|__|__|__|__|

NOT ANSWERED . . . . . -1

Client: Oh, I really don't know exactly. It would be hard to say.

Assessor: Your best estimate would be fine.

Client: Well, if I had to guess, I'd say $450 a month.

MONTHLY INCOME $|0|4|5|0| est.

E. Averaging

If the respondent offers a range to a question for which you can only enter one number, you may take an "average" of the two responses as the answer, after checking the average with the respondent. For example,

Assessor: "How often does your brother come to help you?"

Client: "It varies. Some weeks he comes only once a week and sometimes he comes three times a week."

Assessor: "In the average week or month?"

Client: "It's been about half and half in the last few weeks."

Assessor: "That's about two times a week, on the average, in the last month?"

Client: "That's about right."

The interviewer would code "02."

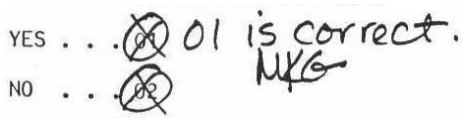
F. Making Corrections

If you circle the wrong answer or if a respondent changes his or her mind, circle the correct code an clearly mark an "X" over the incorrect answer. For example,

YES . . . 01

NO . . . 02

If the respondent should then determine that the first answer was indeed correct, cross through the correction, write the number of the correct answer in the margin and initial it. For example,



VI. SPECIAL ISSUES

A. Confidentiality

One of the most important duties of an interviewer is to protect the confidentiality of data gathered during the assessment process. The responsibility starts with interviewers, but program and agency directors, and senior officials are just as involved.

Data on Individuals are not made available to anyone outside the immediate program. Within the program, access to all data is limited to those who must have it. Safeguards exist which protect these restrictions.

A confidentiality pledge may be signed by all employees to emphasize the importance of confidentiality and to affirm that they accept their responsibility to protect confidentiality. Access to identifying information is limited to those whose administrative roles demand it and only for the period of time they need it. Physical safeguards such as locked file cabinets protect the data and prevent unauthorized access.

By following these guidelines we can ensure that no confidential Information is improperly used.

If respondents are concerned about confidentiality, reassure them that their names do not go into any report, and that reports are statistical with Information reported as totals across large numbers of people.

Confidential information should be shared only with those who have a need to know in order to serve the client, e.g., another service provider. Share only <u>essential information</u>.

B. Dealing with Hearing, Visual, Language, Mobility and Comprehension Problems

Interviewing older impaired persons is basically similar to interviewing persons of any age. There is considerable variation among older people just as there is among persons of all ages. Most of the older persons you will interview will be able to respond to each of the questions. At times, however, you may confront some difficulties. In this section we discuss such difficulties and possible strategies for handling them.

1. <u>Limitations in Hearing</u>

Hearing limitations may be detected by the presence of a hearing aid or by behavioral cues, such as the appearance of inattentiveness or a strained facial expression, particularly when listening. People with hearing limitations may lean toward the interviewer with their "good" sides, tilt their heads, or cup their hands behind their

ears. Others with hearing problems may show none of these behavioral signs but may answer questions inappropriately or frequently ask the interviewer to repeat questions.

The person with hearing limitations may tire easily or show annoyance because of pain or auditory blurring when the interviewer speaks too loudly. It requires a great deal of effort for them to listen and to sort and file sounds into meaningful thoughts, especially when the conversation and the interviewer are both strange to him/her. Hard of hearing persons may tire and give up, so be patient.

Some strategies for handling hearing limitations are:

- Speak in a normal, clear voice directly to the individuals so they can read your lips.
- Avoid speaking in high-pitched tones.
- Speak slowly, without accentuating words, if possible, and wait longer for a reply.
- Do not make sudden movements that could startle the respondent who gets no prewarning from sound.
- Let the client read the questionnaire over your shoulder if necessary and use nodding as a reinforcer.

2. Limitations in Vision

Difficulties in vision may be identified by the presence of thick or dark glasses, a cloudy film over the eyes, or other discoloration in the eyes. However, some visual problems have no obvious signs. In these cases, the interviewer may be able to infer visual limitations by the manner of the respondent's mobility and balance.

Persons with visual loss depend upon immediate sounds and tactile sensations to maintain their sense of security. They may be fearful, distrusting, and awkward in movement.

Some strategies for handling limitations of vision are:

- Hold materials such individuals need to read in the area in which they have the ability to see.
- Use a calm, reassuring voice and speak clearly and distinctly.
- Do not touch or shake hands until you have spoken first.
- Sit where there is no glare and the individual can see you best.

3. Limitations in Language Function

The person with limitations in language function probably knows what he or she wants to say, but is unable to form words. (Do not assume such a person lacks intelligence.) Persons with limitations in language are especially sensitive to the attitude and moods of others and may become irritated over minor incidents. They are often frustrated about their inability to communicate. There may be marked loss of self-confidence and self-worth.

Some strategies for handling limitations in language function are:

- Give the person time to respond without pressure and be attentive.
- Give non-spoken cues and gestures, so that the individual will feel comfortable responding in this fashion.
- Let individuals write if they wish to (and are able).

4. Limitations on Mobility

If a person is limited in mobility or has experienced paralysis you should be careful about the physical arrangements of the interview -- seating, lighting, the availability of a table -- so as to minimize the need for the older person to move or to perform on his/her affected side.

C. Dealing with Emergency and Problem Situations

It is possible that when you ring a doorbell you will discover the client in an emergency situation (acutely ill, just fallen) with no help available. Call the police or other local number for emergency aid and wait until they (or someone else who knows the client) arrive. Call your supervisor as soon as possible and report the situation.

If the client cries or becomes very upset during the interview, you must decide whether to continue. Again, there are no hard and fast rules. In some cases, it may be helpful to divert the client's attention from his/her distress back to the interview. Often, after taking a break, gentle pressure to return to the interview will "seal over" the emotion. In other cases, returning to the interview may have an adverse effect. Use your own judgement, remembering that the only proper role to assume in this situation is that of a case manager, not a counselor.

D. Interviewer Liability

While interviewers are encouraged to carry out small tasks if asked to do so while at the client's home to administer an interview (for example, changing a light bulb,

fetching something, or reaching an item that is on a high shelf), they must heed the following cautions so as not to be held responsible for any adverse consequences of" their well-intended actions.

Frail clients may ask you to help them change positions or move about. Do not move or lift clients, or loosen restraints so they may move about themselves. Handling frail individuals takes special training and you may cause an injury. If you are in a hospital or nursing home, ask the nurse or an aide to help the client. If you are in an individual's home and someone else is present, ask him or her to help. If you are alone with a client, say something like, “I’m sorry, but I’m afraid I might hurt you if I help you in that way."

By the same token do not fetch any food or drink for a client unless you check to be sure he or she is permitted to have it. People at home or in institutions may be on restricted diets because of allergies, health conditions or medical tests. Clients who are confused or disoriented may forget about these restrictions. Others may simply be appealing to your good nature or playing on your sympathy to obtain a forbidden fruit that you may not know is prohibited. Imagine what could result if you gave a candy bar to a diabetic client or a cigarette to a client who was receiving oxygen. Do <u>not</u>, under any circumstances, give medication to a client.

Finally, keep in mind that people who cannot see, hear, or move quickly may be understandably suspicious, because they cannot be certain of what is occurring around them. Do not give them any cause to be suspicious or distrustful of you.

It is important to keep this in mind with respect to getting medication or Medicare and Medicaid cards. For example, you may be told, "My Medicare card Is in my wallet. Please get my pocketbook from the closet in the hallway." When in an individual’s home, do not move about so that you are out of the visual range of someone in the household. You do not want to be accused of stealing or upsetting something in the home. If you are asked to leave the room for some reason, explain that, "Company policy forbids me to walk around your home unless you go with me." If you can get someone's wallet or purse while staying within eyeshot, do not remove anything from the wallet or purse. Hand it to the client so they may take out what they need themselves. Our clinical consultants relate a story of a visiting nurse who helped a patient get something from a wallet and was accused of stealing money that the patient forgot having spent.

Following these few cautions will protect you. Remember, part of your supervisor's Job is to help you. Do ask for advice and information when you need it.

APPENDIX A: QUESTION BY QUESTION REVIEW OF THE CLINICAL BASELINE ASSESSMENT INSTRUMENT

Annotated and Edited by Sheyna Wexelburg-Clouser
September 1983

Introduction

This question-by-question review of the Long Term Care Channeling Demonstration Clinical Baseline Assessment Instrument is designed as both a training tool and basic field reference manual.

Each section of the questionnaire is introduced by explaining the intent of the questions in the section and how they are to be used.

Part 1 of this manual covers the community questionnaire. The institutional version is covered in Part 2. Although both the community and institutional questionnaires gather very similar types of information, there are key differences between them in regard to timeframes and some of the relevant care planning issues. Information covered in this section on the community version is, in general, not repeated for the institutional version if it is applicable to both.

For the most part, these instructions are written as if the client is the respondent for each question. If you are interviewing a proxy respondent, you will need to make the appropriate wording changes that are printed in bold face type on the questionnaire. Sample probes in the question-by-question review do not have the boldface type. They will, however, need to be reworded to be logical for proxy respondents.

The intent of the manual is not to provide an exhaustive review of each question, but rather to point out key definitions and issues the assessor needs to be aware of. The following sections contain 3 kinds of references.

1. References to the actual questions on the C-BAI. These are Indicated by the question number and a brief phrase summarizing the content which Is written in capital letters. e.g. B11 FOOD CONSUMPTION.

   All questions must be answered unless you are specifically instructed to skip around them. The definitions included in this kind of reference must be used at all the sites. These replace the definitions in the old Q x Q.

2. References to the clinical probes on the C-BAI. These are indicated by showing the clinical probe in brackets. For question B11, the example would be [DETAILS]. The suggestions which follow this notation describe the intent of the clinical probe. Note that assessors are <u>not</u> required to use these probes. You must decide whether or not each probe is appropriate for the client being

interviewed. The lines provide a relatively standardized place to record such client-specific information.

3. Suggestions about additional clinical issues. These are indicated by indentation and lower case type. They are intended for the new case manager and should probably be reviewed once during training and once after a few interviews are completed. They are not required and are not intended to be exhaustive.

Reminder About Rules for Administration

1. Code without asking if- know. You may always code a question without asking, if the client has already told you the answer. If you already know part of the answer -- probe for the other part.

2. If the coding options do not appear to accurately describe the situation, code in whichever way will make the situation as clear as possible and supplement with a note.

Section A: Demographic Information

Section A is designed to collect information on demographic information, including marital status, living arrangement, age, education, race, sex, and proximity to children.

Cover Page

Client I.D. Number: Write the I.D. number clearly in the boxes in the upper right hand corner of the page. Write one digit in each box. Fill all boxes.

Respondent: Circle either client or proxy, or both if applicable.

Assessment Interviewer: Write either your name, your I.D. number or both, depending on site preference.

Clinical Notes from the Screen

Before you see the client, transfer notes from the screen which will assist you in the interview. For example, presenting Problems/Reasons for Referral (A12) could be entered here. Names and addresses could be copied from the screen I.D. for verification during the interview. Do not copy information about the client's impairments from the screen, as it may not have come from the client directly and could cause some bias in your responses to the client.

A1 MARITAL STATUS: This question determines current marital status.

[HOW LONG] - Separation means any separation (legal or otherwise) that is due to marital discord.

It would be considered a stressful life event if the client had a change in marital status within the last year. Others include major illness or injury, forced relocation, or death of a friend or family member. These questions are important because stressful events are often associated with declines in emotional, social, or physical functioning and can trigger a chain of circumstances which leads to institutionalization or death.

A2 LIVE ALONE: If the only other member of the client's household is institutionalized, code "YES, ALONE" unless the institutionalization is temporary.

A group home is defined as a dwelling unit in which residents (who are unrelated) do not have a separate entrance from the outside or a common hallway and residents share meals. For example, personal care homes are considered group homes.

If clients are in temporary quarters but plan to return to the home they had previously as of a definite date or when a definite event happens (e.g. removal of cast), code these questions based on their previous home. Usually a stay longer than 60 days is not considered temporary.

A2 [TYPE OF RESIDENCE] - Description of type of housing, e.g. housing for the elderly, boarding home, hotel, apartment, family dwelling.

You may use the space at the bottom of the page for characteristics of the setting or neighborhood important for care planning. For example, access to house, barriers to client's mobility, or proximity of neighbors.

A3- HOUSEHOLD COMPOSITION: By usually live, we mean people for whom the A5 client's usual home is a primary residence; that is, they live with the client half of the time or more.

If there are more than 6 people living in the household, record the first 6 household members mentioned and use the space on the bottom of the page for additional household members. If a household member is institutionalized, see A2.

A4 How old is NAME? An estimate of age is acceptable for this question. If the age of the person is not relevant in any particular case, it may be eliminated.

Note relevant information which clients may mention while describing the household (e.g. "My sister is sicker than I am," "my grandson will never help out," etc.)

A9 YEARS OF SCHOOLING: This question asks for the highest grade or year the client completed in school. Elementary school graduates would be "08." High school graduates would be coded "12." A four year undergraduate degree would be coded "16." Normal school would be coded "14".

A10 RACE/ETHNIC BACKGROUND: Read all categories in order to make it clear that you are reading an existing list to cover all races and that you are not suggesting what race they might be.

If respondents indicate that clients are of mixed racial or ethnic background, probe for their primary race or ethnic background. If, after probing, they do not give a primary race, circle more than one code.

Note here if client would be more comfortable speaking with someone in a language other than English, and what language(s) client reads and writes.

Section B: Physical Health

Data on the elderly clients' physical health are important to assess physical condition, quality of life, clients' attitudes toward their own health, and to predict utilization of medical and health care services.

B1 SELF-PERCEIVED HEALTH STATUS: Self-perceived health status is an important predictor of the utilization of health care services and is an aspect of overall life satisfaction. The question-refers to overall health; thus, if the client mentions a headache or other temporary condition, reread the question stressing overall health.

B2 REGULAR SOURCE OF MEDICAL CARE: While the source of care will usually be a family doctor or clinic, a client may go- to a "healer", "curandero" or other non-traditional source of care. If the client goes regularly to such a source of care, code "YES."

Note client comments on satisfaction with medical care. If the client lists several doctors, find out if one is seen as "in charge".

B3 HOSPITAL ADMISSIONS: An admission is defined as an overnight stay in a hospital.

[DATE] - Accept approximate dates of admission and approximate length of stay is also useful here.

Note if client mentions frequent use of the hospital emergency room (without admission). This can indicate an inadequate use of, or lack of a primary physician.

B5 [ATTITUDES TOWARD NURSING HOME]: Attitude toward nursing home placement is an important predictor of the likelihood of institutionalization and of the use of different kinds of health care services. Asking whether the client has applied to a nursing home may encourage the client to express some strong view on the subject. This space is provided to note client's comments and assessor's observations.

B6-B7 HEALTH CONDITIONS CHECK LIST: Whenever client answers yes in B6, be sure to ask B7 (Are you currently being treated for this condition?)

"Currently being treated" includes any condition for which the client has seen a doctor or other source of medical care within the past three months or for which they are taking prescribed medication or receiving prescribed therapy.

[DETAILS OF HEALTH CONDITIONS] - For how long has a client had a certain health condition or illness? What are the client's limitations because of the health condition? Which doctor is treating which illness? Has client described ways in which s/he is not complying with doctor's orders? Why is client unable to comply? Does client frequently experience pain? Frequent pain may indicate a problem which needs to be addressed.

B8 LIST OF MEDICINES: "Regularly" means medicines routinely taken as needed for some period during the last 3 months.

Probe for other places the client might keep drugs. Note that certain drugs must be refrigerated. (Insulin is one; probe if any diabetic clients do not mention insulin.) Creams and ointments may not be stored with pills.

Is client still taking this medication? What pharmacy does client use? Does pharmacy deliver? Does client have any difficulty getting medicine refilled? Also, note any difficulty in remembering to take medication as well as side effects. If more than one doctor has prescribed the medications, ask if client's primary physician is aware of <u>all</u> the medications client is taking. Does client take dosage as prescribed? Why does client have double prescriptions?

NOTE: The bottom of this page is blank because some sites copy this page from the C-BAI to attach to the back of the assessment summary. This saves the case manager from having to recopy the medicine list and the client's medical condition can be summarized on the bottom half of the page.

B9 MEDICAL TREATMENTS AT HOME: This includes treatments which the client administers to him/herself. You may probe by asking, "Does a nurse come regularly?" Note, however, that treatments do not necessarily have to be administered by nurses.

B10 UNMET NEED FOR MEDICAL TREATMENT AT HOME: This is the first of a series of questions measuring unmet need for assistance in various areas of functioning. People with high levels of unmet need are at risk of institutionalization.

Is client's physician aware that he/she is having difficulty carrying out the treatments?

B11 FOOD CONSUMPTION: The answer to this questions would determine if client is eating a balanced diet. Small amounts of foods used primariy to flavor other foods such as milk in coffee, jelly on toast, butter on bread or catsup on hamburgers do not count as servings. Dried peas are proteins, not vegetables. Potatoes are vegetables, not grains. The purpose of this question is to determine food EATEN, not food served.

Has client experienced a significant weight loss or weight gain recently?

B12 SPECIAL DIET: This refers to a prescribed or recommended diet, or one in which certain foods are prohibited or limited. Kosher, vegetarian and low-salt are all examples of special diets.

Does client have any food allergies? How long has client been on diet? Does client have problems or questions regarding the diet? How closely does client adhere to it?

B13 SPECIAL EQUIPMENT:

[EQUIPMENT USE] - Can the client manage the use of the special equipment? What limitations does the client have in connection with the equipment? Is the equipment in working order? Does the client require instruction in the safe use of equipment? Which equipment is used most of the time?

B14 INDOOR MOBILITY (SPECIFY): Note that there is no codig option for this question. You must write in an answer. Usually means half the time or more during the past week. Note if client walks by holding onto furniture or railings, and/or requires personal assistance.

Is a special assessment indicated? Does assessor's observation of client's ambulation differ from client's self-report? (e.g. client reports independence in ambulation but walks by holding on to

furniture) What is client's attitude toward needing to use special equipment?

B17 OUTDOOR MOBILITY (SPECIFY): Usually means half the time or more during the past week. List all aids which client uses, including personal assistance, specifying which are primary.

B18 VISION:

Does the client indicate the reason for vision problems. What is the impact of vision problems on the client's functioning? Can he/she only read large-type print? Does he/she have difficulty with meal preparation due to vision problems?

Would client be Interested in cassettes of books? In what ways has client compensated for vision problems? (e.g. arranging utensils, furniture in a specific order, etc.)

B19 HEARING: If interviewing a proxy, you will need to ask this as a question.

What is the Impact of hearing problems on the client's functioning? Can the client hear the phone or doorbell ring?

How has client compensated for his/her hearing problems? (e.g. reliance on pets to alert client to doorbell, reads lips, etc). How satisfied is client with hearing aid, raised volume telephone, etc.?

B20 TYPE OF SPEECH IMPAIRMENT: Code this from your observation of the client's speech. If client's speech is normal, note "OK" or "normal". If interviewing a proxy, you will need to ask this as a question.

Section C: Physical Activities of Daily Living

This section of the questionnaire collects information on the client's ability to perform physical activities of daily living (ADL). Because the impact of the demonstration may depend on how impaired an elderly individual is, ADL is an important control variable.

A client who is <u>able</u> to perform a particular ADL task alone (that is, without supervision or active personal assistance) is considered independent in that task, and someone who is <u>unable</u> to perform a particular ADL task alone is considered dependent. The levels of independence are:

- client performs task adequately without the assistance of another person or of special equipment;

- client performs task without the assistance of another person, but requires special equipment.

The levels of dependence are:

- client performs task with assistance or supervision from another person, but the client provides half or more of the effort for performance of the task.

- another person provides more than half of the effort to perform the task.

TIMEFRAME - In general, the timeframe for this series of questions is the previous week; however, if the last week was atypical for a reason which will not continue, use the previous week as your timeframe. The intent-of the questions is to develop a detailed description of the client's ADL abilities and a clear definition of the areas of unmet need. This is necessary in order to identify the problems which need to be addressed in the care plan.

C1 ADL - EATING: Usually refers to half the time or more in the past week.

[WHO HELPS] - If client states that he/she usually has help, probe to determine who assists him/her, what type of help they provide and when they provide it.

Determine how satisfied client is with this arrangement.

C2 ADL - EATING - WAS FED: "Fed" refers to transferring food from a plate or bowl into the client's mouth or holding a glass so that the client could drink.

C3 ADL - EATING - UNMET NEED: If clients report having help (in C1) ask if they feel they need <u>more</u> help. If they report no help, ask if they feel they need help. This pattern should be followed for all unmet need questions.

C5 ADL -TRANSFER - WAS LIFTED: This question measures the level of personal assistance the client has in transfer. A distinction is made between someone who is just supported and someone who is actually lifted.

Special equipment used in transfer includes lifts, hospital beds, sliding boards, "trapezes", or pulleys. It does not include using a cane, walker, or ordinary furniture for support.

If client mentions using a hoyer lift, probe to determine that adequate and safe assistance is available.

C6 UNMET NEED - ADL - TRANSFER: If client is unclear about the need for special equipment, use the examples of special equipment in C5.

C7 ADL - DRESSING - DRESS OR STAY IN NIGHT GLOTHES: A person who gets half dressed, for example, in a shirt and pajama bottom, should be coded "01" for "GOT DRESSED". See C1 if last week was atypical.

C8 ADL - DRESSING: Independence in dressing is defined as getting clothes from closets and drawers and putting them on (including outer garments, and any braces required) and managing fasteners such as buttons, snaps, hooks, or zippers. If the only help someone gets is in tying shoes, do not count this as help. Dressing does not incude help with grooming.

After finding out whether a person gets dressed or stays in night clothes, use the appropriate phrase in the following questions.

C9 ADL - DRESSING - WAS DRESSED: This question determines the level of help the client needed in dressing. A distinction is made between a client requiring some assistance in dressing such as getting the clothes from closets or zipping a back zipper and client who needs to be dressed by a helper. If the client provides less than half of the effort needed for dressing, count that as dressed by others.

C11 ADL - BATHING - METHOD: Our questions refer to the method used most frequently to take a full bath, that is, bathe the entire body. If, for example, clients did not wash their feet or back when they took a bath at a sink but washed themselves completely in the tub, then their usual method of taking a full bath would be in a tub -- even though it may be used less frequently. If, however, clients washed completely both at the sink and in the tub, then their usual method of bathing would be whichever is used more frequently.

Under unusual circumstances, clients may use two methods with equal frequency and be unable to say which they use most. In this case, circle both methods and note that they are used with equal frequency.

Are you able to bathe as frequently as is needed? As you want to?

C14 ADL - BATHING - MORE THAN BACK OR FEET: Many elderly individuals need help washing their backs and feet. This question determines whether the impairment in bathing is more severe than that.

C15 ADL - BATHING - SPECIAL EQUIPMENT: Small items like mitten wash cloths, long-handled brushes or non-slip soap dishes are not considered special equipment.

If the clients indicate that they use special equipment, but don't really ally need it, code "YES"; the question is concerned with use, not need.

Is the equipment in good working order? Any problems in using it? (If client uses more than one type of equipment) which do they use most of the time?

SEE APPENDIX C FOR A DESCRIPTION OF SPECIAL EQUIPMENT.

C17 ADL - TOILETING - USE THE TOILET: These questions are especially important because people who are Incontinent (i.e., those who eliminate urine or feces involuntarily) are at risk of institutionalization.

Code "YES" for people who used the toilet for either their bladder or bowel functions. For example, a client who has a catheter but used the toilet during the past week for bowel movements should be coded "YES, used the toilet", while a client with both a catheter and a colostomy would be coded "NO".

Note if these codes are used, that NO (BEDPAN, BEDSIDE COMMODE) and NO (CATHETER, COLOSTOMY) now have separate codes. Circle the Item that is appropriate.

C18 ADL - TOILETING: Personal help may include any or all of the following: help getting to or from the bathroom, help transferring on or off the toilet seat, help with cleaning after elimination, and help adjusting clothes.

C19 ADL - TOILETING - EQUIPMENT: Examples of special equipment used in toileting are a raised toilet, a raised toilet seat, grab bars, handle bars, and a transfer board. Do not count equipment that helped them get to the toilet such as a cane, wheelchair or walker. Do not count equipment used in transfer to the toilet If it was primarily designed for walking. For example, a walker which is used for support getting off the toilet is not to be counted.

C20 ADL - TOILETING - CATHETER OR COLOSTOMY: Such devices include: colostomy bags, internal catheters, indwelling catheters, condom drainage apparatus, and urosheaths.

SEE APPENDIX D FOR THE DEFINITIONS OF THESE DEVICES

How long has client used the device? Does client have any problems in using the device or obtaining the necessary supplies? Observe the client's attitude towards the use of this device. Is instruction in the use or care of the device indicated?

C21 ADL - TOILETING - HELP WITH EQUIPMENT: If client has both a catheter bag and a colostomy bag, and needs help with only one, circle "Help With Care" and note with which device client needs assistance.

"Changing" the device includes emptying and replacing or replacing the bag. It does not include other types of assistance such as replacing an internal catheter or cleansing the opening of an ostomy.

Section D: Instrumental Activities of Daily Living (IADL)

This section deals with clients' ability to carry out activities of daily living beyond the personal care discussed in Section C. Instrumental activities are meal preparation, housekeeping, shopping, taking medicine, traveling, and using the telephone.

TIMEFRAME: For instrumental activities - In the community version we ask about actual performance of tasks in the past month.

A longer time frame is used for IADL tasks than for ADL tasks because many IADL tasks (for example, shopping and managing money) can occur relatively infrequently. By "past month" we mean the period since the same day of the month one month ago. All of these different time frames are marked in interviewer instructions in the instrument.

SKIP FOR BEDBOUND CLIENTS: Many of the questions in this section can be skipped if the client you are interviewing is bedbound. By bedbound we mean that the client has been unable to get out of bed for more than one month, or when lifted out of bed still cannot ambulate. For such clients, all unmet need questions and questions about activities which could be performed even if bedbound have been marked with a star. At a minimum all starred questions must be asked.

You may decide that you want to ask the other questions in order to find out who helps and how. If you do not get that information here, it will come up on the social support grids. If you do get it here, then code it without asking when the social support grids are being completed.

D1 IADL - MEAL PREPARATION: Note that the frame of reference here is the past month. If someone brings meals to the client which the client reheats, that is considered help with meal preparation. If client eats only light meals such as sandwiches but prepares those meals without help, code them as preparing meals by themselves.

If client reports receiving meals from an agency or organization, probe to determine if meals are received from more than one organizatin, how many meals client receives, and who arranged for the meals to be delivered. Are the meals shared with other household members? If client reports receiving one meal a day, probe to determine if he/she has help preparing their other meals or if the one meals is their only daily source of nutrition. A specific answer is very important for care planning purposes, (e.g. a care

plan for a person who is able but has never learned how to cook would differ from that of person who has crippling arthritis).

D2 IADL - MEAL PREPARATION - REASON FOR HELP: It is necessary to write down the client's answer under (SPECIFY). If there is no answer given, write N/A (for Not Answered) on the line. If you know the answer, write it down without asking.

If the reason given is poor eyesight, probe to determine if someone such as an occupational therapist ever visited to help arrange the kitchen for more convenient use.

D3 IADL - MEAL PREPARATION - LIGHT MEALS: This question determines the level of impairment for those who cannot prepare full meals independently. If the client cannot prepare a light meal at least once a day on a routine basis, code "CANNOT". Ability to prepare a light meal only in an extremely urgent situation is not to be counted.

D5 IADL HOUSEWORK: If the client does some work around the house but others also do some, code as "NO, USUALLY HAS HELP."

[REASON] - Note that in this case 'reason' is a clinical probe and therefore optional. This was done to reduce repetition in questionning.

D6. IADL - LIGHT HOUSEKEEPING: Remember that we want to know whether clients can do these tasks on a routine basis, not only in extremely urgent situations. Using a dishwasher counts as washing dishes.

D8. IADL - GROCERY SHOPPING: If the only help required is transportation, code "Yes, Usually by Self", but note that help is needed for transportation. However, if the person who provides transportation also carries the groceries to the car and into the house, this counts as help. If the clients use a store service such as grocery delivery or telephone shopping, code them as having help. Usually means more than half the time over the past month.

D11 IADL - TAKING MEDICINE: Taking medicine by one's self is defined as rembering to take medicine, getting the medicine and measuring the proper amounts, and actually swallowing the pill, applying the ointment, or giving one's self the injection. If the client requires injections and cannot administer them personally, code as "YES, HAS HELP" even if he/she can take pills by him/herself.

Usually means half the time or more that they took medication during the past month.

D12 IADL - TAKING MEDICINE - REASON FOR HELP: This is presented as a question rather than a clinical probe for two reasons. First, because of its importance, and secondly because the reasons for needing help with medicine may be very different from the reason a person needs help with some of the other IADLs.

D13 IADL - TAKING MEDICINE - LEVEL OF IMPAIRMENT: If help is needed with injections, but not with pills, code as "NO".

D14 IADL - UNMET NEED - TAKING MEDICINES:

Note here any confusion or difficulty the client has remembering to take medications. Would a daily reminder be sufficient to insure client takes prescribed dosages?

D15 IADL - TYPE OF TRANSPORTATION: If the client uses two categories of transporation, for example both buses and taxis, code that mode of transportation is used most often. Make a note of both methods of transportation.

D16 IADL - TRAVEL - LEVEL OF IMPAIRMENT:

[ESCORT NEEDED] - Indicate with a check mark if escort is needed and if client has an escort, write in the name of the person.

D17 HELP WITH TRANSPORTATION FROM AN AGENCY OR ORGANIZATION:

[AGENCY NAME] - Two lines are provided since client may be receiving help from more than one agency. Probe to determine which agency is used most frequently and for which destination. Also ask who arranged for client to receive this assistance.

D19 IADL - MONEY MANAGEMENT: Money management does not refer to handling complicated investments or taxes. It refers to clients' ability to keep track of whatever money they have and includes paying bills, writing checks, handling cash transactions and making change.

If the only help a client gets is transportation (to the bank, for example), but the client handles routine financial transactions like those listed above Independently, circle "YES, USUALLY BY SELF", and note that client needs transportation.

D20 LEGAL GUARDIAN: This question asks clients who do not pay bills by themselves if they have a legal guardian, conservator, or payee.

Legal guardianship is a legal device imposed by a court to provide protection of the estate (i.e., the property including both present and future Interests and/or

claims) and person of an individual adjudged incompetent through the appointment of an individual or agency who takes charge of the incompetent's property and/or claims to manage it for the sole benefit of the incompetent. It results in virtual loss of autonomy for the incompetent. The statutory standards for a finding of incompetency are generally vague, referring to an inability to manage one's affairs because of "insanity", "feeblemindedness", "idiocy", "imbecility", "infirmities of old age", "senility", "drunkeness", or similar terms. Conservatorship is a form of guardianship which, in the states where it is available, relates to a guardianshp of property and typically does not require a finding 'of insanity to have it imposed. It is in many ways, a "junior guardianship" and is supposed to carry less stigma with it. Payee (more correctly, representative payee) is a term limited to Social Security payments made to an individual in behalf of another. The recipient of the check is the representative payee. This does not require a due process hearing and is, in many ways, a "junior, junior guardianship", acquiesced to by the Social Security beneficiary. It is based, usually, upon affidavits of physicians or others and has as it's beneficient purposes the payment of rent and assurance that food is being bought, etc.

How long has client had this arrangement? How satisfied is client with the arrangement? Why does client have a legal guardian/ conservator/payee?

D21 IADL - MONEY MANAGEMENT - LEVEL OF IMPAIRMENT: This question determines level of impairment for clients who do not write checks and pay bills by themselves. Taking care of money for day to day purchases is defined as handling cash and counting money to pay or make change.

D23 IADL - USING THE TELEPHONE - GET NUMBERS AND PLACE CALLS BY SELF: Getting telephone numbers refers to either looking them up, in a directory or calling directory assistance. If client has no phone, ask about his/her ability to use a phone somewhere else. If client is only able to do one function independently, circle "01" ONE ONLY and note which one.

[SPECIAL EQUIPMENT] - If client uses special equipment, note which type and code the answer based on his/her ability to use the telephone with special equipment.

Special equipment in common use includes amplifiers for people with speech and hearing impairments and enlarged dials or number stickers on push button phones for people who are visually impaired. Other less common special equipment includes telephones that are modified to be used with hearing aids, auxiliary receivers for a third party to use in order to sign or repeat words to be lip-read, bone conduction receivers for the hearing impaired, phones hooked up to teletypewriters for those with speech impairments, and signals such as tone

ringers, loud bells, gongs, and phones which switch lights on or off to indicate that the phone is ringing for someone who might not hear a normal phone bell.

Speaker phones and head sets may be used by clients who cannot hold receivers. There are also attachments that allow the receiver to be permanently mounted on an adjustable arm for people who cannot hold a receiver. All these should be counted as phones with special equipment.

D25 ADMINISTRATIVE SKIP - LIVES ALONE: If a client lives alone, code 01 and follow the skip pattern to E7, eliminating questions about help clients may receive from household members.

Section E: Services and Support

This section explores an important part of the channeling demonstration, the role of formal and informal caregivers in providing services and support to channeling clients. A formal caregiver is someone from an agency or organization who provides services or support as a part of their paid or volunteer work. An informal caregiver is a family member or friend who provides services or support. Two major aspects of the evaluation of the channeling demonstration are analyzing the use of formal services the costs incurred, and analyzing the role of informal caregivers in providing services and support for people requiring long term care.

E1 NAMES OF HOUSEHOLD CAREGIVERS: Questions E1-E6 explore the help that clients may get from members of their household. The questions on the grid are in the present tense and refer to clients' current situation. We are interested in the current plan of care. This can include regular help that has been scheduled, but not yet begun such as live-in help.

Be sure the clients are only including people who live with them. Refer to the household composition section (A3-A5). If the clients name more than three household members who help them, ask them to select the three who they feel help the most. Others may be noted in the margin. It is not necessary to determine which of the 3 helps the most; they may be listed in any order.

"NO HOUSEHOLD CAREGIVERS", "-4" - Since those who do not live with others are skipped past this grid, this code should be used only if clients live with others who do not help them. If client is living in temporary quarters or a household member is with client temporarily, gather the data which will be relevant for care planning purposes.

E3 TIMES HOUSEHOLD CAREGIVER AT HOME TO HELP: "Generally" means half the time or more. For example, if caregivers are employed, and only home in the mornings before work, they would not be available to help on week days half the time or more.

E4 HOUSEHOLD CAREGIVER EMPLOYED: Employed is defined as working at a job for wages or salary, full or part-time, including self-employment. This includes live-in staff who are employed in the client's home, as well as household members who work inside the home.

E5 TASKS WITH WHICH HOUSEHOLD CAREGIVER HELPS: Monitoring means staying nearby, but not necessarily in the same room, in case the client needs help. Note that telephone calls to check on the client when the household member is away are excluded. Monitoring does not include a visit by a nurse to take the client's vital signs (temperature, pulse, tec.). Such a visit is considered a medical treatment.

If you find it necessary to read the answer categories as a probe for a hesitant respondent, do not read "Personal Care", use the probe provided. Do not read "Monitoring", ask , "Does NAME stay nearby in case you need help?"

> What is the quality of the relationship the client has with household caregivers? Is help given freely? lovingly? Are household caregivers hostile or begrudging in giving help? Is the household caregiver overwhelmed by all the help the client does need? Does the household caregiver have any relief such as respite care. How does the client feel about the help being received? In your opinion, could the client do more for him/herself? Is the client feeling overwhelmed? Is the client having difficulty accepting a more dependent role?

E7 NAMES OF INFORMAL HELPERS: Assistance provided by telephone or mail is not included in this grid. The informal caregiver must go to see the client to provide assistance.

As in the household caregiver grid, if there are more than three informal caregivers, ask the client to indicate the three who provide the most assistance. Others may be noted in the margin.

E8 RELATIONSHIP OF INFORMAL CAREGIVERS: There may be a fine distinction between friend and neighbor. Code whatever the client indicates the relationship to be.

Any friend or neighbor who comes to help as part of their regular or volunteer work or as a representative of an organization (such as a visitor from a church or temple group) should be coded on the FORMAL SUPPORT SYSTEM grid. Volunteer workers may be hard to distinguish because clients may view them as friends and may be unaware of their organizational affiliation. If you suspect that a friend is a volunteer, probe by asking "Does NAME do that just for you or does

he/she help other people the way he/she helps you, for example through a church group?"

Note that a "live-in" helper does not apply here. "Live-in" helpers belong in the household grid.

E11 DURATION OF INFORMAL CAREGIVER'S VISIT: If some of the help provided happens outside of the visit to clients, include this time in the length of stay. For example, include the time spent shopping for groceries or preparing meals delivered to the clients' homes, doing laundry elsewhere, or running errands.

Write the average time of the visit on the line and circle either HOURS or MINUTES. Estimated are acceptable.

E12 TASKS WITH WHICH INFORMAL CAREGIVERS HELP: See the discussion in E5.

> What is the quality of the relationshp between the client and his/her informal supports? Is the support system able to continue helping the client? Is it stable? If more help was needed, would the informal support system be able to respond? Are there any other contacts important to the client? The landlord? Corner grocer? Any other potential supports in the informal system?

E14 NAMES OF FORMAL HELPERS: This grid concerns the clients' formal support system, that is, people who regularly assist clients as part of their volunteer or paid work. A paid formal helper may be employed by a client, his or her family or by an agency or organization. Care may be provided with or without charge to clients. Staff members of a group care home who do not live in the home are included on this grid as are caregivers from organizations who visit clients in group homes.

If clients are in temporary quarters but plan to return to the home they had previously within 60 days consider the help from formal helpers in their previous home.

Follow the procedures outlined for the previous grid, listing the three most important formal caregivers.

Do not include any helper already listed in the household or informal caregiver grids. If you discover that someone listed in a previous grid belongs in the formal support grid, or that someone mentioned here belongs on another grid, transfer the information to the appropriate grid. When you transfer, check to be sure that you are recording information on the three caregivers who help the most.

We are interested in the current plan of care. This can include regular help that has been scheduled, but has not yet begun.

E15 AGENCY OR ORGANIZATION OF FORMAL CAREGIVER: The exact name of the agency or organization is very important to assist in determining unmet need and for care planning purposes. Ask to see a card or letter from the agency or organization to get the exact name. Often clients will not know because they identify with the person who helps them and not with the organization, or they know the name of the organization that arranged for their services (like a hospital social services department) and not the name of the organization with which the caregiver is associated.

E16 & E17 FREQUENCY AND DURATION OF FORMAL CAREGIVER VISITS: It may be necessary for you to calculate an average and verify it with the client. Use the last month as the time frame in calculating an average. Estimates are acceptable.

E18 TASKS WITH WHICH FORMAL CAREGIVERS HELP:

Note client and family's attitude toward accepting help at home from formal caregivers. How long has client been served by formal providers? Satisfaction with current arrangements.

E20 SOCIAL, RECREATIONAL, OR RELIGIOUS PROGRAM:

Do you eat a meal there? Would you like to attend more frequently?
Does your rabbi/minister/priest visit? Would you like them to?
Would you like to go to your church/synagogue?

[DAILY ACTIVITIES] - How does the client spend a typical day ? Which activities does the client enjoy? Which activities does client like the least? Are there other activities the client would like to try but hasn't yet? Why not?

F1 PSYCHOSOMATIC SYMPTOMS CHECKLIST: This series of questions is designed to help identify whether clients may need psychological services.

If the clients do not "pick up on" the need to answer simply "yes" or "no" for each question, remind them by saying "Would you say yes or no to that question?" Repeat the question if necessary, but do not provide explanations; these may bias the responses. Be aware that these questions might cause the client to become depressed, withdrawn, confused, or tearful. If a client becomes upset, wait quietly for them to regain their composure and then ask gently if it is okay to continue. Use the NO ANSWER code, "-1", for a question that the client is too upset to answer.

F3 COUNSELING FOR PERSONAL PROBLEMS OR EMOTIONAL STRESS: Counseling for personal problems or emotional stress includes individual and group sessions. Counselors include but are not limited to physicians, psychiatrists, psychologists, social workers, and clergy. The counseling can be for interpersonal problems, problems related to family issues, problems caused by drugs and alcohol abuse, emotional problems related to physical limitations or diseases, and other problems for which the client receives mental health or medical social services. This question does not include counseling for financial, legal or nutritional problems.

F5 SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE (SPMSQ): This series of 10 questions forms a valid and reliable scale and is widely used in clinical applications to detect disorientation to time and place and loss of long term memory and of arithmetic ability. It is an important measure of the client's current health condition. You should understand, however, that it is possible for a client who is not confused to miss one or more items on the SPMSQ. Today's date, for example, is often not known by people who are not working. The arithmetic question is difficult for people of any age to answer. Missing a few SPMSQ items, in and of itself, does not mean that the client is unable to provide valid answers to other questions in the interview.

These questions may upset clients. It is easiest to administer them if you are honest and matter-of-fact and READ THE INTRODUCTION VERBATIM. If the client does not know the response and becomes upset, reassure him or her that this is perfectly normal.

A refusal to answer a question usually indicates that the client does not know the answer; so do not pressure the client, code "02".

Not answering, giving an answer that cannot be validated, or giving an incorrect answer are equivalent for the purposes of this scale.

All 10 questions must be asked exactly as written. Allow the client time to think but do not provide "clues". If (after having time to think and the use of probes given in the question), the client still does not know and presses you for the correct answer, you may give it, after scoring the response as "02, INCORRECT/ NOT ANSWERED".

Once an interviewer or assessor has circled "02" (incorrect or not answered) for any question on the SPMSQ, because a client has provided an incorrect answer or has not answered at all within a reasonable time, the answer cannot be changed. Thus, even if a client changes his/her mind immediately after the interviewer or assessor has circled "02" and provides the correct answer, the interviewer must not cross out "02" and circle "01". Do not tell the client that "it is too late". Simply say "OK" and ask the next question.

UNDER NO CIRCUMSTANCES SHOULD YOU ADMINISTER THIS SCALE TO A PROXY RESPONDENT.

PLEASE NOTE: Procedures for determining under what circumstances the SPMSQ will be administered will be decided on a site by site basis. Check with your supervisor if you are unclear about when to use it.

INSTRUCTIONS FOR ADMINISTERING THE SPMSQ: Ask the client questions a-j and record all answers by writing the response on the line and circling CORRECT, INCORRECT/NOT ANSWERED. To be correct, all responses must be given without reference to a calendar, newspaper or other memory aid.

Question a: Score this question as correct only when the exact month, exact date, and the exact year are given correctly.

Question c: This question should be scored as correct if ANY CORRECT DESCRIPTION of the location is given. For example, "my home", the name of the town, city, apartment project, are all acceptable.

Question d: The phone number should be verified from the screening or search information before marking it as correct. Check before beginning the interview whether you have a telephone number for the client. If the client has no phone, or no phone number has been recorded from the screen or your searching, ask for the client's street address and check it against the precoded or searching information on the Baseline Contact Sheet. If you can verify neither telephone number nor address, code, "02".

Question e: Check the birthdate on the screen or contact sheet to verify the correct age.

Question f: The exact date, month and year must be given. Verify it from contact sheet (precoded from the screen).

Question g: The last name only (REAGAN) is required.

Question h: The last name only (Carter) is required.

Question i: This question cannot be verified. Score any last name other than the client's as correct. Although it is possible that clients have the same last names as their mothers' maiden names, we have no independent way to determine mothers' maiden names and check whether the sample members' responses are correct.

Question j: Read the question slowly as worded. If necessary, use the probe provided. For example, if the sample member replies "17" and hesitates for several seconds say, "subtract 3 from that" and so on, for the entire sequence.

To be correct, the entire series must be performed without error. An unwillingness to complete the question should be scored as "INCORRECT/NOT ANSWERED."

After all ten questions are asked, thank the client.

F6 RELIABILITY: This question is not asked of the client, but provides you with the opportunity to evaluate the client's performance as a respondent in terms of his/her understanding of the questions and ability to answer them clearly and accurately. If you did not question the client, circle "-4", NO QUESTIONS ASKED OF CLIENT.

F7 CLIENT BEHAVIOR: This question is not asked of client but is your assessment of client's behavior.

[BEHAVIOR & EMOTIONAL FUNCITONING] - Be specific. Describe any unusual behavior that you saw during the interview, or learned of when talking to a proxy. This may include descriptions of client's strengths as well as inappropriate or problem behaviors observed.

Section G: Financial Resources

This section collects information on insurance coverage, income and assets.

G1 PUBLIC INSURANCE COVERAGE: Insurance coverage is a predictor of service utilization.

a. Medicare Plan A is a federal health insurance program which pays for hospital bills and some skilled nursing home care. People over age 65 are automatically covered if they are eligible for retirement benefits under the Social Security trust fund. (They do not have to be receiving retirement benefits to be eligible for Medicare.)

b. Medicare Plan B covers doctor's bills. It is voluntary coverage and the person must pay for it. The payment is often deducted from Social Security checks. Medicaid sometimes pays for Medicare coverage.

Most people who have Medicare A elect to be covered by Medicare B also. If a client says they have Medicare, probe to find out if both hospital bills and doctor bills are covered, or only hospital bills. You may also probe to find out if the client has anything deducted from their Social Security check for Medicare. If they do, it would be for Medicare B. You may also hear these referred to as Part A and Part B.

If the client has Medicare Part A, circle the A on the line. If the client has both Parts A & B, circle both letters. Code YES (01) if client has any Medicare coverage.

c. Medicaid is publicly subsidized medical care for persons whose income is under certain limits. Your supervisor will tell you if Medicaid is called something else in your area. Your supervisor will also tell you what a Medicaid card looks like in your state so that you can use the description as a probe.

Ask to see the Medicare and/or Medicaid card(s). If the Medicaid card contains a date, check to see that the coverage is current. You may also use a bill or other official record if a card is not available. Write the Medicare or Medicaid card number on the line provided or verify that numbers from the screen are correct.

G2 OTHER MEDICAL AND HEALTH PLANS: G2 is similar to G1 except that it asks if client has any other medical and health plans.

This includes private insurances which supplement Medicare (such as MediGap or Americal Association of Retired Persons) as well as private insurances (such as Blue Cross) which are not Medicare supplements.

VA - refers to medical benefits which are available to veterans and their families, for example, use of Veterans Administration (VA) hospitals. HMO - refers to Health Maintenance Organizations which people join by paying fixed, periodic fees. Membership entitles them to professionals who are associated with the HMO and to hospital coverage. Your supervisor will tell you the names of HMO's in your area.

G3-G4 SOURCES AND AMOUNTS OF INCOME:

If the client is married (see Al), read "you and your (husband/wife)" and fill in either the CLIENT and SPOUSE lines or the BOTH line, depending on how the respondent gives you the information. Do not commplete the BOTH line and one of the other two boxes. If either the husband or wife have income from a particular source and you are using the CLIENT and SPOUSE lines, use a zero on the line for the spouse who has no income from that source. Circle "NOT ANSWERED" if the client does not know the amount of the income.

If the client is separated, widowed, divorced, or never married, fill in the line for client only.

We are interested in income before taxes or deductions.

When a client answers yes to a source of income, proceed to G4, fill in the amount of monthly income received and then continue with the next income source in G3.

a. Social Security or railroad retirement, including Social Security disability payments. These are checks from the federal governemnt. Social Security checks are green. Note, however, that client with vision impairment may have difficulty seeing colors, and those with direct deposit may never see the check.

b. Other checks from the government such as SSI, aid to the blind or disabled, or old age assistance. These checks may be from the federal, state, or local government. Supplemental Security Income (SSI) checks are gold or yellow.

c. Veterans' disability payments - Stress disability benefits. Pensions from military service should be coded in "d", below.

d. Retirement pensions or annuities from government organizations, private employers, unions or military service. This broad category includes retirement pensions form jobs and income from retirement savings plans arranged through one of the sources listed. It also includes retirement plans which people set up for themselves such as Keough or Individual Retirement Account (IRA) plans.

e. Any other income. This category includes, but Is not limited to wages, money from family, disability income (other than veteran's disability), interest or dividends from assets (other than from retirement savings plans that were arranged through one of the sources listed above in "d"), rent from property or rooms, and earnings from small businesses.

Note that money generated through sale or disposal of assets is not income.

G5 TOTAL MONTHLY INCOME: The amount recorded here should be consistent with the answers given in the previous questions (G4 a-e). If not, probe to determine why there is a discrepancy.

G7 ASSETS: For married clients include assets owned by either husband or wife, or by both jointly.

Assets include but are not limited to real estate (for purposes of this question the client's usual home is excluded), savings accounts, savings certificates, stocks, bonds, money market funds, mineral rights, certificates of deposit, furs, precious jewels and metals (including coins), valuable antiques and art, farms or businesses, and motor vehicles worth more than $500.

Probe if the answers to this question on assets are inconsistent with the answers to G4 on income sources. For example, probe if savings accounts are reported (in G7) but interest is not (in G4).

If the client owns a multi-dwelling unit property, like a two-family house or apartment building, this property is considered an asset, even if one of the

apartments in the building is the client's usual home. Do not confuse this situation with the one in which clients, who live in a single family home, rent rooms. In the latter case, this is a usual home and is not considered an asset in this question (although income from rent is included in G5e).

[COMMENTS ON FINANCIAL ELIGIBILITY: FOLLOW SITE-SPECIFIC PROCEDURE] - This space may be used to record financial data needed by your site. Check with your supervisor for further instructions.

Section H:

H1 OWN OR RENT USUAL HOME:

[HOUSING EXPENSES] - This can include rent or mortgage payments, utilities, tax and any other ongoing housing expenses.

H2 GOVERNMENT ASSISTANCE IN PAYING RENT: If clients report living in a public housing project, read "other". (While it would be unusual for a public housing resident to receive other types of governmental assistance, there are no laws or regulations preventing such assistance.)

H4 ARCHITECTURAL BARRIERS OR REPAIR PROBLEMS THAT LIMIT ACCESS TO OUTDOORS: Problems with going outside could be architectural, such as flights of stairs, stairs without special features for the impaired, lack of an elevator, and doorways which will not accommodate wheel chairs. Or problems could be related to a need for repairs, such as a broken elevator, rickety stairs, or dangerous walkways. Use the examples mentioned to probe about problems related to architecture and repairs which the client feels are problematic.

Follow the instruction to circle all answers which apply and ask client to describe problems.

H5-H7 SATISFACTION WITH HOUSING: Please Note that the assessor has the following options in the asking and coding of these three subjective questions: 1) Although the response categories (very satisfied, fairly satisfied, not very satisfied) are still listed, the assessor may omit them when asking the question. 2) Whether or not the assessor uses the response categories when asking the question, if the client's response does not easily fit into one of these categories, the assesor may write the client's own words on the lines provided and not press the client to choose one of the categories offered.

H5 SATISFACTION WITH STATE OF REPAIRS OR MAINTENANCE: Repairs and maintenance refers to both the inside and outside of the building including personal living quarters and shared areas. It does not include the condition of fixtures and furniture.

What needs to be fixed? Did you tell the landlord or building supervisor? When? If necessary, prioritize items with client.

H7 OVERALL SATISFACTION WITH PHYSICAL ENVIRONMENT AS A PLACE TO LIVE:

Variables such as neighborhood, adequate privacy, proximity to friends, noise level and etc., can affect a person's level of satisfaction with their environment. Note specific variables which client mentions.

[SATISFACTION WITH THINGS IN GENERAL] - Use this as a way of completing the interview with the client.

H8 PHYSICAL ENVIRONMENT CHECKLIST: Note: The use of this checklist is to be determined by the site.

Consult your supervisor about your site's policy.

If the checklist is used, please note at the top which dwelling is being rated. Check only if there is a problem.

QUESTION-BY-QUESTION REVIEW OF THE INSTITUTIONAL VERSION OF C-BAI

INTRODUCTION

This section covers the instrument which is administered to clients who are in an institution, either a hospital or a nursing home, at the time of their initial interview.

For the most part the content of the community and institutional versions is identical. When this is true, the manual entries listed in the sections on the community form are not repeated here. In some instances the institutional form has different timeframes, or asks questions about what existed before institutionalization. Some questions, e.g. the unmet need questions, have different instructions. In addition, some questions are skipped if someone has been in an institution for a prolonged period. It is these differences which are highlighted in this section.

DEMOGRAPHIC SECTION

A2 LIVE ALONE: This question asks if the client usually lived alone prior to entering the hospital or nursing home.

A3-A5 HOUSEHOLD COMPOSITION: Here we are asking who usually lived with the client prior to entering the institution. If the client lived in temporary quarters prior to institutionalization, but plans to return to his/her permanent home, code this question based on the home environment relevant for care planning purposes.

A6 RETURNING HOME WHEN DISCHARGED: This question refers to the client's home prior to being institutionalized, that is the home considered in A2-A5.

Use the probe provided in the question if the client is not considering going back to that home and does not explain why. If the client reports no longer owning or renting their former home, circle "02". If the client reports still owning or renting their former, but say they will not return to live there, circle "03".

A7-A11 These questions are the same as the community version but the numbers are different because the institutional form contains an additional question.

PHYSICAL HEALTH

B8 LIST OF MEDICATIONS: When clients are in institutions it saves time to get this information from a nurse. This question documents that you were given verbal permission by the client to do so. If permission was refused or if interviewing a

proxy, you must go ahead and ask about the medications. In either case remember to probe about eyedrops, suppositories, injections, etc.

When discussing medications with a nurse, ask which are expected to continue when the client is discharged. Another medication review may be appropriate after the client returns home.

B9 MEDICAL TREATMENTS AT HOME: Emphasize at home in the community. If a client is to be discharged to another institution (e.g., from a hospital to a nursing or convalescent home), you must clarify for him/her that we mean after he/she is discharged from all institutions. This includes treatments which are self administered.

B10 UNMET NEED FOR MEDICAL TREATMENT AT HOME: The question measures prospective unmet need, that is, unmet need that will exist when the client returns to the community after being discharged from all institutions. Unmet need exists if clients will need more help than is currently arranged for them or they are certain will be available to them when they return to the community.

If the client is uncertain about his or her condition, about how much help will be available, or about what the doctor will order or allow, code their response as “UNCERTAIN”. This same pattern is followed for all UNMET NEED questions in the institutional form.

B11 FOOD CONSUMPTION: Institutions are required to serve a balanced diet, but we want to know what the client actually eats.

How does this differ from what they usually eat at home? Why?

B12 SPECIAL DIET: This question is asked of a nurse if possible, since the client may not know what special diet he/she is on.

Will this special diet be necessary when the client returns home?

B15 DIFFICULTY WITH STAIRS: In institutions, people are often moved around In wheelchairs even though they usually get around indoors in some other fashion. This is especially likely to happen if the client is being interviewed in a waiting room or administrative office that is not near their room. If you suspect that the client is in a wheelchair because of institutional rules or procedures, you should ask question B15 rather than coding "05" for "IN WHEELCHAIR" without asking.

PHYSICAL ACTIVITIES OF DAILY LIVING

C11 ADL - BATHING - METHOD: Please note that the skip instructions are missing from this question. They should be:

IN TUB OR SHOWER 01
IN SINK OR BASIN 02 (C13)
BED BATHS 03 (C16)
DID NOT HAVE A FULL BATH 04 (C16)
NOT ANSWERED . . . . . -1 (C13)

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Many of the questions in this section start with the phrase "Considering how you have been feeling the past week, could you ...". This is done to help clients be somewhat realistic in their answers, even though they haven't performed the activities in some time.

Also note that many of the questions have probes to try to get the capacity of the client to perform, even though the situation doesn't permit performance. For example, if a client says "they do all the cooking for me here", repeat the question by saying "If that were not the case, could you ...", or "If someone else didn't do it, could you ...".

For all of the activities, if a doctor tells the client that he/she is not allowed to perform the activity, the answer should be coded as "no", even If the client disagrees with the doctor's opinion. We wouldn't want to plan services based on the client's noncompliance with his/her medical regimen.

E. SERVICES AND SUPPORT

E1, E7, E14 The questions on the three grids refer to people who regularly helped the client before Institutionalization. Some of the questions should be reworded to ask them in the past tense in order to avoid confusing the client. e.g. "When is NAME generally at home to help you if you need it", should be changed to "When was NAME generally at home....".

Although the information being gathered here is a description of the client's situation before institutionalization, it is important to note In the margin any changes which have occurred since then in the availability of these helpers. (e.g. daughter is now employed full time.)

[INVOLVEMENT IN CASE MANAGEMENT PROGRAM PRIOR TO INSTITUTIONALIZATION]: If the client had been receiving formal services prior to admission to the hospital or nursing home, you may wish to determine whether he/she was involved in a case management program. Possible probes include:

"Who arranged for you to receive these services?"
"Was there a social worker who worked with you?"
"Did someone regularly check on the services you received?"

H. PHYSICAL ENVIRONMENT

H4 SATISFACTION WITH HOUSING: If the client has been in a hospital or nursing home for more than two months and is not returning to his/her usual home, skip these questions and terminate the interview. Use your judgement about asking them if the person is not returning to his/her home but has been institutionalized a shorter time. It is possible that dissatisfaction with that environment contributed to the decision not to return to it after discharge.

CLINICAL BASELINE ASSESSMENT INSTRUMENT SET

PDF Files Available for This Report

Main Report http://aspe.hhs.gov/daltcp/reports/cbainstr.pdf

Clinical Baseline Assessment Instrument: Community Version
http://aspe.hhs.gov/daltcp/reports/cbaicv.pdf

Clinical Baseline Assessment Instrument: Institutional Version
http://aspe.hhs.gov/daltcp/reports/cbaiiv.pdf

This full report is also available in **HTML** format at:
http://aspe.hhs.gov/daltcp/reports/cbainstr.htm